Supreme Court, U.S.
FILED
MAY 31 2000

(3)

No. 99-1738

IN THE

Supreme Court Of The United States

CHILDREN'S SEASHORE HOUSE,

Petitioner

v.

MICHELLE K. GUHL, Commissioner of the New Jersey Department of Human Services, and MARGARET A. MURRAY, Acting Director of the New Jersey Department of Human Services, Division of Medical Assistance,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF *AMICI CURIAE* NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AMERICAN HOSPITAL ASSOCIATION, VHA INC., PREMIER, NATIONAL ASSOCIATION OF URBAN CRITICAL ACCESS HOSPITALS, CATHOLIC HEALTH ASSOCIATION, AND CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS IN SUPPORT OF PETITIONERS

James C. Rawls
Counsel of Record
Larry S. Gage
Charles Luband
Lisa Meengs
Powell Goldstein Frazer & Murphy LLP
1001 Pennsylvania Ave., N.W.
Suite 600
Washington, DC 20004
(202) 347-0066

Attorneys for Amici Curiae

May 31, 2000

Balmar Legal Publishing Services, Washington, DC 20005 (202) 682-9829

32 pp

TABLE OF CONTENTS

INTEREST OF THE PARTIES 1

SUMMARY OF THE ARGUMENT 1

ARGUMENT 3

I. THE COURT SHOULD GRANT THE PETITION BECAUSE THE MEDICAID DSH PAYMENT PROVISIONS ARE CRITICAL TO OUR NATION'S ABILITY TO CARE FOR THE POOR AND UNINSURED, AND HOSPITALS MUST HAVE THE POWER TO ENFORCE THE RIGHTS THAT THE CONGRESS INTENDED TO CREATE FOR THEM 3

A. The History of the DSH Payment Provisions Reflects a Long-Term and Continuing Congressional Intent to Protect Hospitals Treating a Disproportionate Number of Low-Income Patients 4

B. Enforceable Rights to DSH Enhancements are Essential to the Care of Medicaid and Uninsured Patients 8

II. THE COURT SHOULD GRANT THE PETITION TO REMEDY THE THIRD CIRCUIT'S MISAPPLICATION OF THIS COURT'S PRECEDENTS 11

A. The Third Circuit Failed to Apply *Blessing v. Freestone* Appropriately to Determine Whether a Private Right of Action Existed Under 42 U.S.C. § 1983 in Regard to the New Section 1902(a)(13)(A) or Section 1923 of the Medicaid Act 11

B. The Boren Amendment Repeal Does Not Change the *Blessing* Analysis or its

Outcome, and the History of the Balanced Budget Act of 1997 Demonstrates that The Congress Intended to Preserve and Strengthen the DSH Program 16

III. THE THIRD CIRCUIT HOLDING ESTABLISHES A CONFLICT AMONG THE CIRCUITS THAT WILL CREATE CONFUSION AMONG OTHER COURTS..... 19

CONCLUSION..... 20

TABLE OF AUTHORITIES

CASES

Blessing v. Freestone, 520 U.S. 329 (1997) ..... *passim*

Boatman v. Hammons, 164 F.3d 286 (6th Cir. 1998) 20

Chevron U.S.A., Inc. v. Natural Resources Defense Council, 467 U.S. 837 (1984) 19

Children's Hosp. and Health Ctr. v. Belshe, 188 F.3d 1090 (9th Cir. 1999), *petition for cert. filed*, 68 U.S.L.W. 3595 (Mar. 9, 2000) (No. 99-1497) 19

Children's Seashore House v. Waldman, 197 F.3d 654 (3d Cir. 1999) 2, 12, 13

Concourse Rehabilitation & Nursing Ctr. v. Wing, 150 F.3d 185 (2d Cir. 1998) 20

District of Columbia Hosp. Ass'n v. District of Columbia, 73 F. Supp. 2d 8 (D.D.C. 1999) 11

Doe v. Chiles, 136 F.3d 709 (11th Cir. 1998) 20

Golden State Transit Corp. v. City of Los Angeles, 493 U.S. 103 (1989) 12

Harris v. James, 127 F.3d 993 (11th Cir. 1997) 20

Harris v. McRae, 448 U.S. 297 (1980). 16

Mississippi Hosp. Ass'n v. Heckler, 701 F.2d 511 (5th Cir. 1983) 6

Orthopaedic Hosp. v. Belshe, 103 F.3d 1491 (9th Cir. 1997) 20

Osteopathic Hosp. Founders Ass'n v. Splinter, 955 F. Supp. 1351 (N.D. Okl. 1996) 11

Rite Aid of Pennsylvania v. Houstoun, 171 F.3d 842 (3d Cir. 1999) 20

Rye Psychiatric Hosp. Ctr. v. Surles, 777 F. Supp. 1142 (S.D.N.Y. 1991) 11

Pages

Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990) ..... *passim*

STATUTES, REGULATIONS AND RULES

42 U.S.C. § 1396a(a)(13)(A), Section 1902(a)(13)(A) of the Social Security Act ..... *passim*

42 U.S.C. § 1396r-4, Section 1923 of the Social Security Act ..... *passim*

42 U.S.C. § 1983 ..... *passim*

Pub. L. No. 96-499, § 962, 94 Stat. 2650-51 (1980) ..... *passim*

Pub. L. No. 97-35, § 2173(a)(1)(B)(i), 95 Stat. 808 (1981). 4, 5

Pub. L. No. 99-272, § 9519, 100 Stat. 216-217 (1986) 6

Pub. L. No. 100-203, § 4112, 101 Stat. 1330 (1987) 4, 6

Pub. L. No. 102-234, § 3, 105 Stat. 1799-1804 (1991) 8

Pub. L. No. 103-66, § 13621(b), 107 Stat. 312 (1993) 8

Pub. L. No. 105-33, 111 Stat. 514 (1997) 8, 18

63 Fed. Reg. 54142 (Oct. 8, 1998) 18

64 Fed. Reg. 54263, 54267 (Oct. 6, 1999) 18

Sup. Ct. R. 10 3

OTHER

H.R. Rep. No. 97-158 (1981). 5

H.R. Rep. No. 100-391(I) (1987) 6, 8

H.R. Rep. No. 105-149 (1997) 17

H.R. Conf. Rep. No. 105-217 (1997) 17

Institute Of Medicine, Summary: America's Health Care Safety Net, Intact But Endangered 4 (2000) 8, 10

Lynne Fagnani & Jennifer Tolbert, The Commonwealth Fund, The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid

Disproportionate Share Hospital Payment Programs 19 (1999).....10

INTEREST OF THE PARTIES[1]

Amici curiae are associations and networks of hospitals, health systems and other healthcare providers with a strong shared interest in proper administration and enforcement of statutory requirements of the Medicaid Act, which is found in Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (hereinafter "Medicaid Act" or "Act"). A full description of each of the individual organizations is included in the attached Appendix. Many members of the *amici* associations and networks are healthcare providers that serve disproportionate numbers of Medicaid recipients and other low-income patients, and are thus recognized by state Medicaid programs under the federal Medicaid statute as providers entitled to receive additional payments. Such providers are often called "disproportionate share hospitals," and the additional payments are often referred to as Medicaid "DSH payments."

The Third Circuit's holding below threatens the ability of DSH hospitals to use the legal process to ensure that states carry out the DSH payment requirements imposed on them by the Medicaid statute. This case is therefore of great importance to such hospitals, insofar as the inability to enforce statutory Medicaid payment requirements could weaken and ultimately destroy the fragile health care safety net that serves the nation's most vulnerable low-income residents.

SUMMARY OF THE ARGUMENT

This case concerns the rights of hospitals under the Medicaid Act. It involves two distinct but related provisions

---

[1] This brief was authored solely by counsel for the *amici curiae*. No person or entity other than the *amici* listed herein has made a monetary contribution to the preparation or submission of this brief. Petitioner and respondents have consented to the filing of this brief. Letters expressing consent to that effect have been filed with the Clerk of the Court.

of the Act -- Section 1902(a) (42 U.S.C. § 1396a), which establishes minimum requirements for state Medicaid plans including the requirements in Section 1902(a)(13)(A), and Section 1923 (42 U.S.C. § 1396r-4), which provides particular standards for the recognition and payment of DSH hospitals. These provisions together create what is commonly referred to as the Medicaid DSH payment program.

The issue raised by this case from the perspective of *amici curiae* is quite simple: Whether disproportionate share hospitals have a right of action under 42 U.S.C. § 1983 that may be enforced against states that refuse to comply with the Medicaid DSH payment requirements in Sections 1902(a)(13)(A) and 1923. The Third Circuit found no enforceable statutory right under either section. *Children's Seashore House v. Waldman*, 197 F.3d 654, 659 (3d Cir. 1999).[2] This holding is inconsistent with Supreme Court precedent and conflicts with decisions by other circuits.

If the decision below is allowed to stand, the ability of disproportionate share hospitals to enforce the DSH payment provisions of the Medicaid Act is threatened. A strong, enforceable Medicaid DSH payment program is essential to the delivery of health care services to low-income patients in the absence of universal health insurance coverage. As a result, this case is important not only to *amici* and the provider-members they represent, but also to the estimated 40 million Medicaid recipients and 44 million uninsured individuals who rely on those providers for essential health care.

In addition, the Third Circuit misapplies this Court's precedents in determining whether a right exists under 42 U.S.C. § 1983 to enforce the statutory entitlement to DSH payments. *See Blessing v. Freestone*, 520 U.S. 329 (1997). The court below relies on tangentially relevant legislative action (i.e., the repeal of a completely different statutory requirement

---

[2] The text of the Third Circuit's decision is available in Petitioner's Brief at Pet. Br. App. 3a-19a.

known as the "Boren Amendment") and unrelated legislative history in reaching its holding that the DSH payment provisions are unenforceable under 42 U.S.C. § 1983. *Children's Seashore House*, 197 F.3d at 659. A proper analysis using this Court's standards, however, reveals that an enforceable right continues to exist.

The holding below also creates a multi-faceted conflict among the circuits. In particular, the circuits are split regarding whether private rights of action exist under the Medicaid Act, and also regarding the impact of the repeal of the Boren Amendment on the determination of such rights. This conflict will lead to confusion and additional inconsistent rulings on a matter of substantial importance if not addressed by this Court.

ARGUMENT

Rule 10 of the Rules of the Supreme Court of the United States sets forth the considerations governing review on a Petition for Writ of Certiorari. Certiorari is proper in this case because it presents an issue of substantial importance to the nation's low-income patients and the providers that serve them. In addition, the Third Circuit has misapplied Supreme Court precedent in reaching its holding. Finally, in ruling that disproportionate share hospitals cannot sue to enforce relevant provisions of the Medicaid Act, the Third Circuit has created a direct conflict among the circuits.

I. THE COURT SHOULD GRANT THE PETITION BECAUSE THE MEDICAID DSH PAYMENT PROVISIONS ARE CRITICAL TO OUR NATION'S ABILITY TO CARE FOR THE POOR AND UNINSURED, AND HOSPITALS MUST HAVE THE POWER TO ENFORCE THE RIGHTS THAT THE CONGRESS INTENDED TO CREATE FOR THEM

In 1981, the Congress amended the Medicaid Act to require that state payment methodologies take into account the situation of hospitals that serve disproportionate numbers

of low-income patients. Pub. L. No. 97-35, § 2173(B)(ii), 95 Stat. 808 (1981) (amending predecessor to current 42 U.S.C § 1396a(a)(13)(A)). While the states were given some flexibility in implementing the DSH payment provisions, in 1987 the Congress clarified and reinforced this mandate by requiring states to deem certain facilities as disproportionate share hospitals, and requiring states to select from among alternative minimum payment methodologies in setting DSH payment rates for those hospitals. Pub. L. No. 100-203, § 4112, 101 Stat. 1330 (1987) (enacting 42 U.S.C. § 1396r-4).

Pursuant to the Medicaid DSH payment program, states must provide enhanced payments to designated providers in order to assist in covering costs that would otherwise be uncompensated. As detailed in the DSH payment provision itself, such costs include the costs of serving uninsured patients, and the difference between Medicaid payments and the costs of providing services to Medicaid eligibles. 42 U.S.C. § 1396r-4(g). In the context of a rapidly growing uninsured population and intense competition for health care dollars, the Medicaid DSH payment program has become essential to the ability of hospitals to ensure that every American has access to health care services. Contrary to the Third Circuit's assertions, the Congress not only has refused to take action to relieve states of their obligation to DSH hospitals, it has actually imposed additional DSH requirements on states. Yet, the Third Circuit holding threatens to undermine this important program by removing a right of action allowing hospitals to enforce its requirements.

A. The History of the DSH Payment Provisions Reflects a Long-Term and Continuing Congressional Intent to Protect Hospitals Treating a Disproportionate Number of Low-Income Patients

Amici curiae have been extensively involved in the development, modification, and implementation of the Medicaid DSH payment provisions. Prior to 1980 states were required to pay nursing facilities and hospitals serving Medicaid patients their reasonable costs, based on Medicare

principles of provider reimbursement. H.R. Rep. No. 97-158 at 292 (1981). If a state wished to deviate from using Medicare principles, it could do so only by obtaining a waiver. In 1980, the Congress amended the Medicaid Act to provide states with greater flexibility to reimburse nursing facilities based on alternative payment methods without need for a waiver. However, in an amendment first proposed by Oklahoma Senator David Boren, this flexibility was limited in that states were required to find and make satisfactory assurances to the Secretary that their rates were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards ...." Pub. L. No. 96-499, § 962, 94 Stat. 2650-51 (1980) (hereinafter "Boren Amendment"). In 1981, the Congress expanded this additional flexibility in setting Medicaid payment rates to include hospitals. Pub. L. No. 97-35, § 2173(a)(1)(B)(i), 95 Stat. 808 (1981).

In granting states permission to establish new hospital payment methodologies, the Congress simultaneously made clear its concern for the fiscal viability of hospitals that treat "a large volume of Medicaid patients and patients who are not covered by other third party payors." H.R. Rep. No. 97-158 at 294 (1981). To address these concerns, in addition to the Boren Amendment requirement that overall rates be "reasonable and adequate," the Congress also mandated that payment for inpatient services should "take into account the special costs of hospitals whose patient populations are disproportionately composed of [such] individuals." *Id.* at 295. The Act was amended to include the requirement that rates, "in the case of hospitals, take into account the situation of hospitals that serve a disproportionate number of low income patients." Pub. L. No. 97-35, § 2173(a)(1)(B)(ii), 95 Stat. 808 (1981).

Although the history of the DSH provisions is related to the history of the Boren Amendment, it is not identical, and

the purposes of the two provisions differ. In fact, when the Boren Amendment was originally enacted for nursing facilities in 1980, the DSH provisions were not included (and to this day do not apply to nursing facilities). While the Boren Amendment focused on ensuring that overall provider reimbursement rates were "reasonable and adequate," the DSH program's intent was to provide additional funding for hospitals that primarily serve Medicaid and uninsured patients. *See Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 519 (5th Cir. 1983) ("[The Boren Amendment] was enacted in 1981 primarily to encourage cost containment in the Medicaid program .... The Congress nevertheless added the [DSH language] to assure that the needs of hospitals with special costs due to a disproportionate number of poor patients were taken into account"). Thus, from its beginnings, the DSH payment requirement was separate from the Boren Amendment's "reasonable and adequate" standard.

Five years later, the Congress became concerned about reports that states were not properly implementing the 1981 DSH payment provision and directed the Secretary of the Department of Health and Human Services (hereinafter "Secretary") to prepare a study reporting on state progress. Pub. L. No. 99-272, § 9519, 100 Stat. 216-217 (1986). The report showed that only 27 states had even defined disproportionate share hospitals and that of these, only 15 states were actually making DSH payment adjustments. H.R. Rep. No. 100-391(I) at 525 (1987).

Indifference to the 1981 DSH provision was not limited to the states. In some instances, the Health Care Financing Administration ("HCFA") of the U.S. Department of Health and Human Services, which administers the Medicaid program, actively deterred states from implementing the DSH payment provision. Recognizing this "startling record of noncompliance," in 1987 the House Budget Committee adopted language in the Omnibus Budget Reconciliation Act of 1987 to enumerate the DSH requirements. Pub. L. No. 100-203, § 4112, 101 Stat. 1330 (enacting 42 U.S.C. § 1396r-4)

(hereinafter OBRA '87). In OBRA '87, the Congress enacted a number of requirements intended to mandate compliance with the original 1981 DSH provision. OBRA '87 provided that:

> A State plan ... shall not be considered to meet the requirement of section 1902(a)(13)(A) ... (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) ... unless [it] ...
>
> > (A) specifically defines [disproportionate share hospitals] ..., and
> >
> > (B) provides ... for an appropriate increase in the rate or amount of payment for [inpatient hospital] services provided by such hospitals ...

Id. at § 4112(a)(1) (42 U.S.C. § 1396r-4(a)(1)). The Congress further deemed certain hospitals to be disproportionate share hospitals and therefore entitled to enhanced payments. *Id.* at § 4112(b) (42 U.S.C. § 1396r-4(b)). Finally, the Congress provided specific instructions on alternative ways for states to calculate the level of DSH payments. *Id.* at § 4112(c) (42 U.S.C. § 1396r-4(c)). The provisions enacted by OBRA '87 are filled with mandatory language, including directives that states and the Secretary "must" or "shall" follow certain procedures in implementing the DSH program.[3] The Congress intended through OBRA '87 to establish once and for all that the DSH provisions were mandatory and to set minimum standards for states and

---

[3] *See* 42 U.S.C. §§ 1396r-4(a)(1) ("A state plan under this subchapter *shall not* be considered to meet the requirement of section 1396a(a)(13)(A) ... unless ...), (a)(2)(A) ("[T]he State *must* submit to the Secretary ... (a)(2)(B) ("In order to be considered to have met such requirement ... the State *must* submit ..."), (a)(3) ("The Secretary *shall* ..."), (c) ("[A] payment adjustment for a disproportionate share hospital *must* ...") (emphasis added).

HCFA to follow in implementing the program. H.R. Rep. No. 100-391(I) at 525 (1987). The Third Circuit below erred in finding that this statutory scheme did not confer enforceable obligations on the states that were separate and distinct from those of the repealed Boren Amendment. *See infra* § II(A).

The Congress has taken no action since 1987 that can reasonably be construed as diluting or repealing the specific DSH requirements imposed by OBRA '87. If anything the Congress has increased the number of requirements in the DSH provisions through subsequent legislation.[4] While the Congress clearly repealed the Boren Amendment in the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 514 (1997) (hereinafter "BBA"), it took great care to preserve the DSH requirement in Section 1902(a)(13)(A) and actually enacted additional DSH requirements in Section 1923. *See infra* § II(B).

B. Enforceable Rights to DSH Enhancements are Essential to the Care of Medicaid and Uninsured Patients

There are an estimated 40 million Medicaid recipients in the United States and an additional 44 million individuals without health insurance. The number of uninsured has increased by 11 million over the past decade, and is expected to continue growing at a significant rate. Institute Of Medicine, Summary: America's Health Care Safety Net, Intact But Endangered 4 (2000) (hereinafter "IOM Report"). The uninsured, along with low-income underinsured Americans, Medicaid recipients, and patients with special

---

[4] In 1991 the Congress created a national DSH payment target and limited the growth of state DSH programs. Pub. L. No. 102-234, § 3, 105 Stat. 1799-1804 (1991) (42 U.S.C § 1396r-4(f)). In 1993, the Congress placed hospital-specific restrictions on the amount of DSH payments. Pub. L. No. 103-66, § 13621(b) (1993) (42 U.S.C. § 1396r-4(g)).

needs rely on a committed core of "safety net" hospitals for the majority of their health care services. These are the disproportionate share hospitals.

Disproportionate share hospitals are a major source of care for poor Americans. At a time when no consensus exists for adoption of universal health coverage, disproportionate share hospitals step in and provide a kind of national health plan by default. In addition to the substantial volumes of inpatient care typically provided by these safety net institutions, they are major providers of primary and preventive care through both primary care and specialty clinics. Many of these institutions also provide high cost, under-reimbursed specialty care relied upon by the entire community, including trauma care, burn units, neonatal intensive care, and emergency psychiatric services.

Being a safety net hospital, however, is an expensive proposition, and resources to cover the enormous amount of unreimbursed care provided are few and far between. Medicaid, a significant payer for these institutions, often pays less than the true cost of care.

Funding for care to the uninsured and underinsured is extremely fragile. Hospitals once funded uncompensated care largely through "cost shifting"[5] to private sector payers, but are no longer able to do so as competition and managed care have driven down payments to hospitals. Direct governmental support for hospitals treating low-income Americans is therefore extremely important. In addition to Medicaid DSH, sources of such support include a smaller Medicare DSH program, federal categorical grant programs, and state and local government subsidies. None of these are

---

[5] Historically, governmental payers frequently paid less than the costs of care to patients sponsored by public programs but private payers typically paid more than the costs of care. Providers used the excess from private patients to subsidize losses on publicly insured and uninsured patients, thus indirectly "shifting the cost" of public patients to private payers.

of the same magnitude as Medicaid DSH, and most have been cut back in recent years. Through this patchwork of support, safety net hospitals have managed to meet the overwhelming demand for their services, but just barely. A threat to any one of these sources of support is a direct threat to continued access to care for low-income patients. The fragility in the institutional financing of care to low-income patients endangers the quality and quantity of services available to those patients in the future. *See generally* IOM Report.

With this backdrop, it is difficult to overemphasize the importance of Medicaid DSH payments for safety net hospitals. Since the Congress' reinforcement of the DSH requirements in OBRA '87, Medicaid DSH has enabled hospitals to care for low-income patients. In 1998, nearly $15 billion was spent by the federal government and the states on Medicaid DSH payments. A study by *amicus* National Association of Public Hospitals & Health Systems (NAPH) revealed that its members (who are almost all disproportionate share hospitals) would have experienced a negative 13 percent margin on Medicaid payments and a negative 7 percent margin on total operations in the absence of DSH payments. Lynne Fagnani & Jennifer Tolbert, The Commonwealth Fund, The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs 19 (1999). Only after DSH payments were included were hospitals able to cover some of their otherwise uncompensated costs. Clearly, DSH payments are essential to providing health care access for millions of low-income Americans.

Hospitals' right to DSH adjustments, however, would be severely undercut if the decision below is allowed to stand and they lose the ability to enforce that right. Several of the detailed requirements set forth in Section 1923 confer rights that HCFA is not actively involved in overseeing and must therefore be enforced by the provider itself if they are to have meaning. For example, the requirement that states deem certain providers as DSH providers, 42 U.S.C. § 1396r-4(b),

or the requirement that payments be made directly to providers and not through managed care arrangements, 42 U.S.C. § 1396r-4(i), are rights that can mean millions of dollars in DSH payments for an individual hospital but are not actively enforced by HCFA. Recourse through the courts is the only option for hospitals wrongfully denied such rights.[6] A right of action to enforce the DSH provisions is therefore key to a meaningful DSH payment program. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 514 (1990) (noting that removing the right to sue for violations of the Boren Amendment "would render [the provision] a dead letter"). Loss of the ability to sue states to enforce DSH provisions would have a significant impact on safety net providers and the patients they serve.

II. THE COURT SHOULD GRANT THE PETITION TO REMEDY THE THIRD CIRCUIT'S MISAPPLICATION OF THIS COURT'S PRECEDENTS

A. The Third Circuit Failed to Apply *Blessing v. Freestone* Appropriately to Determine Whether a Private Right of Action Existed Under 42 U.S.C. § 1983 in Regard to the New Section 1902(a)(13)(A) or Section 1923 of the Medicaid Act

Section 1983 imposes liability on anyone who, under color of state law, deprives a person "of any rights, privileges, or immunities secured by the Constitution and laws" of the United States. 42 U.S.C. § 1983. In order to seek redress under this provision, a plaintiff must assert the violation of a

---

[6] *See, e.g., District of Columbia Hosp. Ass'n v. District of Columbia*, 73 F. Supp. 2d 8, 20 (D.D.C. 1999) (finding that defendants ignored "their legal duties as set forth in the governing Medicaid statute" related to DSH payments); *Osteopathic Hosp. Founders Ass'n v. Splinter*, 955 F. Supp. 1351 (N.D. Okl. 1996) (considering a claim regarding plaintiff's rights to DSH payments); *Rye Psych. Hosp. Ctr. v. Surles*, 777 F. Supp. 1142, 1150-1153 (S.D.N.Y. 1991) (considering plaintiff's claim that the state's refusal to declare it a disproportionate share hospital violates Section 1923 of the Act).

federal right, not merely a violation of federal law. *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989). This Court has been very clear in articulating the standards for evaluating a private right's enforceabity under 42 U.S.C. § 1983. Under its reasoning in *Blessing v. Freestone,* an enforceable right exists if three tests are met:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforceability would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision must be couched in mandatory rather than precatory terms.

520 U.S. 329, 340-41 (1997) (internal citations omitted). *See also Wilder*, 496 U.S. 498. While the Third Circuit gives lip-service to the three-part *Blessing* test in reaching its holding, it does not complete the "methodical inquiry" demanded by this Court.[7] *Blessing*, 520 U.S. at 343.

Contrary to the Third Circuit's analysis, a proper inquiry using the *Blessing* standards demonstrates that enforceable rights exist under either the combination of Section

---

[7] After quoting the three-part *Blessing* test, the Third Circuit below merely states:

> [B]y replacing the Boren Amendment with a requirement that a state establish a public process by which its rates would be determined, Congress has removed a party's ability to enforce any substantive right ... Thus, unless [Section 1923] establishes an enforceable right on its own, CSH does not have an enforceable statutory claim ... We are satisfied that CSH cannot predicate its claim on these provisions.

Children's Seashore House, 197 F.3d at 659-660. Without looking at the statute, the Third Circuit relies on legislative history and a district court case to determine that no right exists under Section 1902(a)(13)(A).

1902(a)(13)(A) and Section 1923 or on the basis of Section 1923 standing alone.[8] Under the first prong of *Blessing*, there is little doubt that the Congress intended the DSH provisions to benefit disproportionate share hospitals, since the provisions establish a system for enhanced Medicaid reimbursement of these providers. *Children's Seashore House v. Waldman* (D.N.J. Dec. 7, 1998), Pet. Br. 20a, 27a (district court below found that petitioner and "hospitals like petitioner" were intended beneficiaries of Section 1923). *See also Wilder*, 496 U.S. at 510 ("[H]ealth care providers are the intended beneficiaries [of Section 1902(a)(13)(A)]").

Having satisfied the first test of *Blessing*, the next question is whether the rights provided in Sections 1902(a)(13)(A) and 1923 are not too "vague and amorphous" to be enforced without straining judicial competence. The first point of reference should be the statutory requirements.

The Third Circuit is plainly incorrect in stating that the current Section 1902(a)(13)(A) does not substantively require compliance with the DSH statute. *See Children's Seashore House*, 197 F.3d at 659 ("by replacing the Boren Amendment with a ... public process ... Congress has removed a party's ability to enforce any substantive right"). The federal Medicaid Act clearly imposes specific requirements on states in developing hospital payments and also clearly requires that "in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs." 42 U.S.C. § 1396a(a)(13)(A)(iv). In 1997, the Congress added the parenthetical requirement that such rates must be "consistent with section 1923."

Although Section 1902(a)(13)(A) primarily addresses public notice requirements, the reference to Section 1923 is a

---

[8] *Amici* adopt and incorporate the more detailed arguments contained in the Petitioner's brief regarding the application of *Blessing* to *Children's Seashore House*. *See* Pet. Br. at 17-19.

reference to more detailed processes for implementing the substantive right. Conversely, Section 1923 itself acknowledges that it is detailing requirements for implementing the substantive right conferred by Section 1902(a)(13)(A)(iv). *See* 42 U.S.C. § 1396r-4(a)(1) (acknowledging that Section 1902 "requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs"). The language of Section 1923 makes clear that the Congress considers the DSH payment requirement in Section 1902(a)(13)(A)(iv) to be substantive. The requirement is not "vague and amorphous," and it gives rise to an enforceable right.

Moreover, Section 1923 is adequately specific to confer enforceable rights on its own. The section sets forth a number of substantive provisions, including the requirement that a plan amendment "specifically define" disproportionate share hospitals and "include" those hospitals meeting the minimum requirements in the statute. 42 U.S.C. § 1396r-4(a)(1)(A). The statutory requirements also provide two detailed formulae for determining minimum eligibility, 42 U.S.C. § 1396r-4(b), a requirement that states "provide[] for an appropriate increase in the rate or amount of payment for [inpatient] services provided by [disproportionate share] hospitals," 42 U.S.C. § 1396r-4(a)(1)(B), and three alternative methodologies for making payment adjustments, 42 U.S.C. § 1396r-4(c). Whether in conjunction with Section 1902(a)(13)(A) or not, these requirements are concrete and enforceable by the courts.[9]

---

[9] *Amici* believe that Section 1902(a)(13)(A) also contains procedural protections that are substantive rights enforceable under 42 U.S.C. § 1983. Apparently concluding that the "public process" language of Section 1902(a)(13)(A) does not include a substantive right, the Third Circuit concludes that there is no enforceable right in the section. This Court acknowledged in *Wilder* however, that procedural rights can be enforced under § 1983. 496 U.S. at 513 ("Any argument that the requirements . . . are procedural requirements only and do not require the State to adopt

The rights at issue in this case are analogous to those examined in *Wilder* and found by the Court to allow a cause of action under § 1983, even though *Wilder* involved the "reasonable and adequate" requirements of the Boren Amendment. *Wilder* noted that Boren was cast in "mandatory rather than precatory terms," quoting the language that a state plan "must" "provide for payment" according to reasonable and adequate rates. 496 U.S. at 512. In the instant case, a state plan "must" "take into account ... the situation of hospitals which serve a disproportionate number of low income patients with special needs." 42 U.S.C. §§ 1396a(a)(13)(A)(iv), 1396r-4. The *Wilder* court also emphasized that the "provision of federal funds is expressly conditioned on compliance" with the requirements in Section 1902(a) – a fact that has not changed with the repeal of the Boren Amendment. 496 U.S. at 512. Finally, the *Wilder* Court rejected an argument that the only right enforceable under 42 U.S.C. § 1983 is "the right to compel compliance" with "bare procedural requirements" as opposed to a substantive right to reasonable and adequate rates. 496 U.S. at 513. The reason for rejecting this argument in *Wilder* applies equally to the rights at issue in this case: to do otherwise "would render the statutory requirements of ... the entire reimbursement provision, [sic] essentially meaningless ... We decline to adopt an interpretation ... that would render [the provision] a dead letter." 496 U.S. at 514. Applying the rationale of *Wilder* to Sections 1902(a)(13)(A) and 1923 in this case, the second prong of *Blessing* is satisfied.

---

rates that are actually reasonable and adequate is nothing more than an argument that the State's findings and assurances need not be correct"). Even the dissent in *Wilder*, while arguing against a substantive right to "reasonable and adequate" rates, recognized that a right to enfoce the process established by the statute existed. 496 U.S. at 527-28 ("establishment of rates in accordance with that process is the only discernable right accruing to anyone under § 1396a(a)(13)(A)").

Finally, as required by *Blessing's* third prong, the requirements in Sections 1902(a)(13)(A) and 1902 are binding. It is well settled that although a state's participation in the Medicaid program is voluntary, if a state chooses to participate, its Medicaid plan must comply with the state plan requirements in Section 1902(a) of the Act.[10] *Harris v. McRae*, 448 U.S. 297 (1980). Section 1923 is drafted in mandatory terms and provides specific, enforceable directives for states to follow in implementing Medicaid DSH. Neither of these sections expresses "merely a Congressional preference for a certain kind of conduct," but rather they impose a "binding obligation" on states to treat this special class of hospitals differently. *Wilder*, 496 U.S. at 509.

The Third Circuit violated this Court's dictates in refusing to find that Sections 1902(a)(13)(A) and 1923 meet the *Blessing* requirements.

B. The Boren Amendment Repeal Does Not Change the *Blessing* Analysis or its Outcome, and the History of the Balanced Budget Act of 1997 Demonstrates that the Congress Intended to Preserve and Strengthen the DSH Program

The Third Circuit largely relies on the repeal of the Boren Amendment to support its holding. However, this legislative action did not alter the independent DSH payment requirement or the outcome of the *Blessing* analysis. In fact, the legislative history surrounding the Boren Amendment

---

[10] These requirements include, for example, that the plan be mandatory in all political subdivisions of the state; that the state provide for an opportunity for a fair hearing to any individual denied assistance under the Medicaid program; that the state provide safeguards which restrict the use or disclosure of information concerning applicants or recipients of Medicaid assistance; that the state provide for a minimum list of services to Medicaid recipients. 42 U.S.C. §§ 1396a(a)(1), (3), (7), (10). The DSH provision found in Section 1902(a)(13)(A)(iv) incorporating Section 1923, or Section 1923 alone, is no less enforceable under § 1983 than any of these other requirements. See *infra* § III.

repeal supports the assertion that the Congress intended for the DSH provisions to remain enforceable.

In adopting the BBA of 1997, the Congress was clearly troubled by the "reasonable and adequate" provisions in the Boren Amendment. Unlike the precise DSH requirements created by OBRA '87, the Congress never defined the Boren Amendment's "reasonable and adequate" standard. As a result, states and hospitals quickly turned to litigation to give the provision clearer meaning. The crucial case on point was *Wilder*, where this Court held that the "reasonable and adequate" language created an enforceable right. 496 U.S. at 524.

The Congressional reports accompanying the BBA reflect widespread concern with the amount of litigation spawned by the "reasonable and adequate" standard of Section 1902(a)(13)(A) and a desire to grant states more flexibility in rate-setting. *See, e.g.*, H.R. Conf. Rep. No. 105-217 at 867-68 (1997) ("A number of courts found that state systems failed to meet the test of 'reasonableness'"); H.R. Rep. No. 105-149 at 547 (1997) ("Many states have argued that suits or threats of suits under the Boren Amendment have been an important cause of rapid increases in provider reimbursement rates").

Yet nowhere in the volumes of committee reports, floor statements, and testimony on the BBA does anyone in the Congress express a desire to repeal the DSH requirement or render it unenforceable. Rather, the Congress was very deliberate in retaining language in the new Section 1902(a)(13)(A), as well as in Section 1923, requiring states to continue to "take into account ... the situation of hospitals which serve a disproportionate number of low-income patients." To underscore its intent, Congress added a new parenthetical reference within Section 1902(a)(13)(A) to the more specific requirements of Section 1923. *See supra* § II(A). Congress intended to retain the DSH requirement, not to repeal that requirement along with the Boren Amendment. The Conference Report in its characterization of the House Bill further emphasizes this intent. H.R. Conf. Rep. No. 105-217 at 867-68 (1997).

Moreover, despite the repeal of the "reasonable and adequate" requirement by the BBA, the Congress was contemporaneously strengthening the Medicaid DSH program. Specifically, the Congress enacted new language at Section 1923(a)(2) that requires "the State [to] submit to the Secretary ... a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals ... [and] provide an annual report to the Secretary describing the disproportionate share payments to each disproportionate share hospital." Pub. L. No. 105-33, § 4721(c), 111 Stat. 514 (1997) (42 U.S.C. § 1396r-4(a)(2)(D)). The Congress stated that a state plan "shall not be considered to meet the requirements of section 1902(a)(13)(A)(iv)" if these reports are not made. *Id.*; *see also* H.R. Conf. Rep. No. 105-217 at 875 (1997) ("states must submit [information] ... [and] shall make an annual report to the Secretary"). The Congress also added a new requirement that DSH payments made on behalf of Medicaid patients enrolled in managed care plans be paid directly to hospitals rather than the managed care organizations. Pub. L. No. 105-33, § 4721(d), 111 Stat. 514 (1997) (enacting Section 1923(i), 42 U.S.C. §1396r-4(i)).

HCFA clearly believes a substantive DSH mandate still applies. On December 10, 1997, HCFA sent a letter to state Medicaid Directors implementing the new Section 1902(a)(13)(A) and noting the DSH requirement as one of "a number of existing statutory and regulatory requirements . . . [that] remain." On October 8, 1998, HCFA issued a notice in the Federal Register regarding the reporting requirements in Section 1923(a)(2)(D). 63 Fed. Reg. 54142 (Oct. 8, 1998) ("If a title XIX State plan does not specify this methodology by October 1, 1998, it is not in compliance with section 1902(a)(13)(A) of the Act."). On October 6, 1999, HCFA promulgated a proposed rule implementing the new Section 1902(a)(13)(A) which continues to recognize the need to "take into account (in a manner consistent with section 1923 of the Act) the situation of hospitals which serve a disproportionate number of low-income patients." 64 Fed. Reg. 54263, 54267 (to be codified at 42 C.F.R. § 447.254(a)) (proposed Oct. 6, 1999). HCFA clearly

does not believe that the DSH payment requirements have been compromised, and HCFA's interpretation in this instance should be accorded deference. *See Chevron U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984).

The Third Circuit incorrectly relied on the repeal of the Boren Amendment and a case addressing the "reasonable and adequate" provisions of the former Section 1902(a)(13)(A) to find no enforceable right under the current Section 1902(a)(13)(A). The DSH requirement is distinct from the "reasonable and adequate" provisions of the Boren Amendment and must be considered on its own under the *Blessing* analysis. By finding no enforceable right, the Third Circuit ignores the clear intent of the Congress and diminishes the substantive requirements contained in the DSH provisions.

III. THE THIRD CIRCUIT HOLDING ESTABLISHES A CONFLICT AMONG THE CIRCUITS THAT WILL CREATE CONFUSION AMONG OTHER COURTS

Amici adopt and support Petitioner's description and analysis of the conflicts created by the Third Circuit's holding with prior holdings by the Ninth Circuit, and ask the Court to resolve the conflict regarding the enforceability of the DSH payment provisions. In addition, the decision below adds to substantial existing confusion among the circuits with respect to determining whether a right of action exists under provisions of the Medicaid Act. Review of the instant case by the Court provides an opportunity to alleviate substantial confusion.

Although the circuit courts generally recognize *Blessing* as providing the test for determining whether a right exists, there is little to no consistency in the courts' application of the test. A number of the circuit courts, with varying results, have evaluated whether an enforceable right of action exists in regard to Medicaid state plan requirements.[11] The proper application of *Blessing* to

---

[11] *Compare Children's Hosp. and Health Ctr. v. Belshe*, 188 F.3d 1090 (9th Cir. 1999) (recognizing an enforceable right to DSH payments), *petition for cert. filed*, 68 U.S.L.W. 3595 (U.S. Mar. 9, 2000) (No. 99-

Medicaid Act requirements remains unclear. The Court should grant review both to address the specific conflict regarding the enforceability of the DSH payment provisions and to alleviate confusion regarding the application of the *Blessing* test to Medicaid plan requirements.

CONCLUSION

For the above stated reasons, we urge the Court to grant the petition for a writ of certiorari.

Respectfully submitted,

James C. Rawls
Counsel of Record
Larry S. Gage
Charles Luband
Lisa Meengs
Powell, Goldstein, Frazer & Murphy LLP
1001 Pennsylvania Ave., N.W.
Suite 600
Washington, DC 20004
(202) 347-0066

Attorneys for Amici Curiae

1497); *Concourse Rehabilitation & Nursing Ctr. v. Wing*, 150 F.3d 185 (2d Cir. 1998) (assuming without deciding that state plan requirements create enforceable federal rights); *Boatman v. Hammons*, 164 F.3d 286 (6th Cir. 1998) (finding an enforceable right to a state plan that is "in effect in all political subdivisions of the state"); *Doe v. Chiles*, 136 F.3d 709, 715-718 (11th Cir. 1998) (finding an enforceable right to "reasonable promptness"); *and Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997) (recognizing an enforceable in the Act's "efficiency, economy, and quality of care" provision), *cert. denied*, 522 U.S. 1022 (1998) *with Rite Aid of Pennsylvania v. Houstoun*, 171 F.3d 842 (3d Cir. 1999) (rejecting a right of action in the "efficiency, economy, and quality of care" provision); *and Harris v. James*, 127 F.3d 993, 1010-1012 (11th Cir. 1997) (rejecting a right of action in multiple provisions of the Act).

APPENDIX A

Amici curiae include the following organizations with strong interest in preserving the Medicaid DSH payment program and the right to sue for enforcement of the program's requirements.

National Association of Children's Hospitals (N.A.C.H.)

Representing more than 110 hospitals across the country, including Children's Seashore House and the Children's Hospital of Philadelphia, the National Association of Children's Hospitals (N.A.C.H.) was founded in 1995 as a nonprofit trade association. N.A.C.H. assists its members in addressing public policy issues affecting their ability to fulfill their four-fold missions of providing clinical care, education, research and public health advocacy devoted to all children. An independent corporation, N.A.C.H. is the public policy affiliate of the 32 year-old National Association of Children's Hospitals and Related Institutions (NACHRI), a charitable institution. N.A.C.H. members are among the nation's premier pediatric safety net institutions, pediatric physician and allied health professional training programs, pediatric biomedical and health services research centers, and advocates for children's public health and well-being.

More than 20 percent of all children and 30 percent of all infants rely on Medicaid to pay for their health care; another 11 percent of children are uninsured. Due to their mission to meet the clinical care needs of all children, regardless of economic or medical need, children's hospitals on average devote close to half of their patient care to children who are assisted by Medicaid or are uninsured. Almost every freestanding children's hospital is recognized by its state to be a "disproportionate share hospital" (DSH), and in many states, children's hospitals are among the leading safety net hospitals in receipt of DSH payments. These payments are often substantial, averaging more than $5 million per hospital, and are essential to the sustainable financial health of the hospital.

Without DSH payments, children's hospitals on average receive less than 75 percent reimbursement for their Medicaid expenditures. All of the children's hospitals' missions are affected by the adequacy and reliability of their DSH payments.

National Association of Public Hospitals & Health Systems (NAPH)

The National Association of Public Hospitals & Health Systems (NAPH) was founded in 1981 and represents over 100 metropolitan area hospitals and health systems across the country. These hospitals and systems typically serve as safety net institutions in their communities and are heavily reliant on governmental sources of financing to support care. In 1997, just 69 NAPH members provided nearly one quarter of the uncompensated care in the United States. Over 80 percent of services provided by NAPH members are provided to Medicare, Medicaid, and uninsured patients. Over 65 percent of inpatient care is provided to Medicaid and uninsured patients. The average NAPH member has uncompensated care costs in excess of $61 million, representing over 26 percent of total costs in each institution.

Medicaid DSH payments are of critical importance to NAPH members in subsidizing care provided to the Medicaid population and to the uninsured. Virtually every NAPH member is recognized as a disproportionate share hospital. Medicaid DSH payments provide 22 percent of the funds used to finance the uncompensated care that NAPH members provide. In comparison, only 4 percent of uncompensated care is financed through cost shifting. Without DSH payments, NAPH members would face considerable losses and many would likely be unable to survive.

Association of American Medical Colleges (AAMC)

The Association of American Medical Colleges (AAMC) is a non-profit association whose membership includes 125 U.S. medical schools, 16 Canadian medical schools, and more

than 400 teaching hospitals and health systems. The AAMC's primary mission is to improve the health of the public by enhancing the effectiveness of academic medicine.

In 1998 the AAMC collected financial and operating data from 180 hospital and health system members. Of those members, 54 received Medicaid DSH payments. The mean DSH payment was $32.2 million, and the median payment was nearly $9.7 million. On average, this represents almost 8 percent of net patient service revenue.

American Hospital Association (AHA)

The American Hospital Association (AHA), a not-for-profit association founded in 1898, is the primary national membership organization for hospitals and health systems in the United States. Its membership includes nearly 5,000 hospitals, health systems, networks, and other health care providers. The AHA's mission is to advance the health of individuals and communities; the AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement.

Well over 95 percent of the AHA's members participate in the Medicaid program, providing more than $36 billion worth of hospital services to Medicaid patients annually. Because of the important role Medicaid disproportionate share hospitals (DSH) play in their communities, and their dependence on Medicaid DSH payments to serve as safety net hospitals for the most vulnerable Medicaid, uninsured, and underinsured patients, the AHA has a keen interest in seeing that disproportionate share hospitals receive the funding intended for them by Congress. The AHA's advocacy on behalf of Medicaid hospitals and the patients they serve includes participation as *amicus curiae* before this court, e.g. *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498 (1990).

VHA Inc. (VHA)

VHA Inc. (VHA) is a nationwide network of community-owned health care systems and their physicians.

VHA has more than 1,900 members representing over one quarter of the nation's community-owned hospitals and representing some of the nation's leading health care institutions. VHA was founded in 1977 to help preserve the not-for-profit health care philosophy of providing health care. VHA organizations are in 48 of the nation's states (excluding Nevada and Utah).

VHA provides products, programs, and services to help members provide the best possible health care to their patients and communities. VHA offers its members contracts on regional and national products and services in areas such as clinical effectiveness, information technology, learning networks and education, market-share development, performance improvement, and supply-chain management.

Premier

Premier is a strategic alliance of leading hospitals and healthcare systems across the country, representing 212 owners and the 956 hospitals and healthcare facilities they operate, as well as approximately 900 other affiliated hospitals. In addition to offering hospitals substantial pricing discounts through group purchasing agreements, Premier provides a broad-based package of services to its hospital affiliates. Premier has a sizeable stake in the outcome of legislative and regulatory initiatives and is active in the political process regarding issues that enhance healthcare providers' ability to delivery quality care. Premier maintains major offices in Charlotte, NC; San Diego, CA; Chicago, IL; and Washington, DC.

National Association of Urban Critical Access Hospitals (NAUCAH)

The National Association of Urban Critical Access Hospitals (NAUCAH) represents hospitals providing a wide spectrum of services to patients in urban areas. Urban critical access hospitals are located in cities, and are both private and non-profit. They are big and busy, with a bed size of over

250, or total hospital days at or above the 60th percentile of hospitals in comparably sized Metropolitan Statistical Areas. Of more than 6,000 acute-care hospitals in the U.S. fewer than 300 meet all of these criteria.

At least 60 percent of their patient days are reimbursed by Medicare and Medicaid, and at least 10 percent of their patient days are Medicaid days. They also provide a significant amount of charity care. The manner in which urban critical access hospitals are reimbursed gives them a special relationship with the federal government because they are in effect almost totally dependent on government for their reimbursement - and for their survival. Medicare and Medicaid make up the majority of their reimbursement, in many cases it is virtually all of their reimbursement.

Medicaid and Medicare DSH payments are essential for the survival of these hospitals. These payments allow them to maintain their mission and serve low-income and elderly residents in their communities.

Catholic Health Association (CHA)

The Catholic Health Association of the United States (CHA) is the national leadership organization representing the Catholic health ministry. CHA's more than 2,000 members form the nation's largest group of not-for-profit Catholic healthcare systems, sponsors, facilities, health plans, and related organizations. Since its founding in 1915, CHA has worked to strengthen the Catholic health ministry so that it can provide care to everyone, particularly the poor and those least able to care for themselves. CHA is headquartered in St. Louis and has an office in Washington, DC.

Catholic healthcare has a long history of service to low-income communities in the United States, pre-dating the Medicaid program by more than 150 years. On a daily basis, Catholic hospitals provide care to thousands of Medicaid beneficiaries and uninsured individuals consistent with our mission. Adequate Medicaid DSH payments are essential to these hospitals' ability to maintain a strong presence in their communities.

California Association of Public Hospitals and Health Systems (CAPH)

The California Association of Public Hospitals and Health Systems (CAPH), established in 1983, is a trade association representing more than two dozen hospitals, health care systems, and academic medical centers throughout California. Also called "open door providers" because no one is denied access to the essential health care services they provide, CAPH members share a mission and a mandate to provide care to all residents, regardless of their ability to pay. These providers are dedicated to assure the accessibility of cost-effective, high quality, and culturally appropriate health care services for low-income and uninsured populations, beyond those emergency and stabilization services required by law.

CAPH advances public health policies that promote community health, enhance access to health care services for all Californians, support the role of open door providers, and preserve the public health care safety net. CAPH also serves as a resource for information and assistance to members on a variety of state and federal health care policy issues, and has expertise on the Medicaid DSH payment program and other issues of importance to open door providers.